BlueCross BlueShield Minnesota

Sun Life

A. GROUP EMPLOYEE ENROLLMENT AND CHANGE FORM

Employee's Last Name	First Name	M.I.	Date of Birth	Social Security Number	Home Phone

Employee's Home Address	Street	City	State	Zip Code	Work Phone

Employee's Email Address

B. LIST ALL INDIVIDUALS TO BE ADDED OR CANCELLED—COMPLETE ALL THAT APPLY (use extra paper if necessary)

Relation (Circle)	Last name	First Name	M.I.	Cancel Eff. Date	Add/ Cancel	Sex	Marital Status	Social Security #	Birth Date (Mo. Day Yr.)
Self					Add Cancel	M F	Married Single		
Spouse					Add Cancel	M F	Married Single		
Child Stepchild					Add Cancel	M F	Married Single		
Child Stepchild					Add Cancel	M F	Married Single		
Child Stepchild					Add Cancel	M F	Married Single		

C. BENEFIT SELECTION -- CIRCLE APPROPRIATE WORD TO ELECT OR WAIVE COVERAGE

Health: ⬭ Single ⬭ Family ⬭ None

Health Plan Product Name: ⬭ $500 ⬭ $3,500 ⬭ $6,350

Dental: ⬭ Single ⬭ Family ⬭ None

For Life Insurance benefit, please indicate Beneficiary name and Relation to self:

Primary Beneficiary name_____ Relation to self_____

Contingent Beneficiary_____

I UNDERSTAND THAT PROVIDING FALSE INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

_____

Signature of employee Date signed

D. MEDICARE AND OTHER COVERAGE INFORMATION

Will you, or any person listed above be covered by other health insurance or Medicare while enrolled under this coverage? Yes No

If yes, you must complete the following (for Medicare, list both Part A and B effective dates):

Name of policy holder	Insurance company and address	Medicare or policy #	Type of coverage (single or family)	Effective date

If Medicare; check reason for entitlement ⬭ Age ⬭ Disability ⬭ End-stage Renal Disease ⬭ Disability End-stage Renal Disease

E. COVERAGE CHANGE INFORMATION -- CHECK APPROPRIATE BOX(ES)

Adding dependents:	Date of event	Cancelling dependents:	Date of event
⬭ Birth/adoption	_____	⬭ Divorce	_____
⬭ Court Order	_____	⬭ Other (explain in details):	_____
⬭ Marriage	_____	County: _____	
⬭ Other	_____	Details: _____	

Loss of prior health and/or dental coverage:

Did you lose health coverage?: ⬭ Yes ⬭ No

⬭ Address change

⬭ Phone number change

⬭ Name change

	Date of Event
⬭ Other coverage voluntarily terminated	_____
⬭ Group continuation (COBRA) period exhausted	_____
⬭ Employer contribution for coverage terminate	_____
⬭ Coverage terminated due to loss of eligibility	_____

Reason: _____

F. THIS PART TO BE COMPLETED BY EMPLOYER

Employee's date of employment:	Employee's Occupation:	Hours worked per week:

Monthly salary (Complete only if applying for salary based benefits) $_____

Indicate the reason employee is enrolling for coverage::

⬭ New Employee ⬭ Rehire (length of layoff): _____ ⬭ New Group

⬭ Return from leave of absence (length of absence): _____ ⬭ Certificate of coverage termination

⬭ Previously waived Coverage ⬭ Change from part-time to full-time ⬭ Other: _____

Date of event: _____

Group numbers:	Health	Dental	Life	LTD

I certify the above information to be true and correct.

Signature: _____ Date: _____

Employer name: